Exhibit A:

Psychological Studies on the Aftermath of Abortion from 2002

Prepared by

Priscilla K. Coleman, Ph.D.

Psychology of Abortion Studies Published Since 2002

Publication information	*Comparison groups*	*Data source and sample demographics*	*Outcomes examined*	*Controls*	*Positive methodological Features*	*Results*
1) Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (2002). **State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over four years**. *American Journal of Orthopsychiatry, 72,* 141-152.	Women who aborted (n=14,297) or delivered a child (n=40,122) while receiving medical assistance from the state of California (Medi-Cal) in 1989 and who had no psychiatric claims for 1 yr prior to pregnancy resolution. Delivery group had no subsequent abortions.	**California Department of Health Services Medi-Cal data** All low–income Delivery: Avg. age: 25.4 Avg. number of mos. of eligibility: 27 Abortion: Avg. age: 24.6 Avg. number of mos. of eligibility: 31	Out-patient mental health claims – total number and numbers for specific diagnoses	- Pre-pregnancy psych-ological difficulties - Age - Months of eligibility	- Used actual claims data, eliminating the concealment problem - Avoids recruitment and retention problems - Eliminated cases with previous psychological claims - With claims data, avoids simplistic forms of assessment - Comparison groups are likely very similar except for the abortion experience - Extended time frame, with repeated measurements enabling more confidence in the causal question	Within 90 days after pregnancy resolution, the abortion group had 63% more total claims than the birth group, with the percentages equaling 42%, 30%, 16%, and 17% for the 1st 180 days, yr 1, yr 2 and across the full 4-yr study period respectively. Across the 4-yrs, the abortion group had 21% more claims for adjustment reactions than the birth group, with the percentages equaling 95%, 40%, and 97% for bipolar disorder, neurotic depression, and schizophrenia respectively.
2) Reardon, D. C., Cougle, J., Rue, V. M., Shuping, M., Coleman, P. K., & Ney, P. G. (2003). **Psychiatric admissions of low-income women following abortion and childbirth.** *Canadian Medical Association Journal,* 168, 1253-1256.	Women who aborted (n=15,299) or delivered a child (n=41,442) while receiving medical assistance from the state of California (Medi-Cal) in 1989 and who had no psychiatric claims for 1 yr prior to pregnancy resolution. Delivery group had no subsequent abortions.	**California Department of Health Services Medi-Cal data** All low–income Delivery: Avg. age: 25.5 Avg. # of mos. of eligibility: 27 Abortion: Avg. age: 24.8 Avg. # of mos. of eligibility: 31	In-patient mental health claims – total number and numbers for specific diagnoses	- Pre-pregnancy psych-ological difficulties - Age - Months of eligibility	- Used actual claims data, eliminating the concealment problem - Avoids recruitment and retention problems - Eliminated cases with previous psychological claims - With claims data, avoids simplistic forms of assessment - Comparison groups are likely very similar except for the abortion experience - Extended time frame, with repeated measurements enabling more confidence in the causal question	Within 90 days after pregnancy resolution, the abortion group had 160% more total claims than the birth group, with the percentages equaling 120%, 90%, 111%, 60%, 50%, and 70% for the 1st 180 days, yr 1, yr 2, yr 3, yr 4, and across the full 4-yr study period respectively. Across the 4-yrs, the abortion group had 110% more claims for adjustment reactions than the birth group, with the percentages equaling 90%, 110%, and 200% for depressive psychosis, single and recurrent episode, and bipolar disorder respectively.

Publication information	*Comparison groups*	*Data source and sample demographics*	*Outcomes examined*	*Controls*	*Positive methodological Features*	*Results*
3) Reardon, D. C., Cougle, J., Ney, P. G., Scheuren, F., Coleman, P. K., & Strahan, T. W. (2002). **Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study.** *Southern Medical Journal, 95*, 834-841.	Women who aborted or delivered while receiving medical assistance from the state of California (Medi-Cal) in 1989 and died between 1989 and 1997 (n=1,713)	**California Medi-Cal records and death certificates** All low–income Delivery: Avg. age: 25.6 Abortion: Avg. age: 24.8	Death due to various violent and natural causes	- Pre-pregnancy psych-ological difficulties - Age	- Used actual claims data, eliminating the concealment problem - Eliminated cases with previous psychological claims - Avoids recruitment and retention problems - Comparison groups are likely very similar except for the abortion experience - Covered 8 yrs post-pregnancy	- With adjustments for age, women who aborted when compared to women who delivered were 62% more likely to die from any cause. More specific percentages are given below. Violent causes: 81% Suicide: 154% Accidents: 82% All natural causes: 44% AIDS: 118% Circulatory disease: 187%, Cerebrovacular disease: 446% Other heart diseases; 159% - Fairly similar results were obtained when we controlled for prior psychiatric history as well.
4) Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (2002). **History of induced abortion in relation to substance use during subsequent pregnancies carried to term.** *American Journal of Obstetrics and Gynecology, 187*, 1673-1678.	Women who carried a pregnancy to term with a history of one prior abortion (n=74) were compared to women with one prior birth (n=531) and no prior pregnancies (n=738)	**National Pregnancy and Health Survey** Avg. age: 26.5 yrs Marital status Married: 71.5% Not married: 29.5% Ethnicity Hispanic: 18.4% Black: 11.4% White: 64.3% An avg. of 5 yrs had elapsed since a prior abortion and an avg. of 3.42 yrs since a prior birth.	Substance use of various forms during pregnancy	Results were stratified by potentially confounding factors (marital status, income, ethnicity, and time elapsed since a prior abortion or birth)	- Nationally representative, racially diverse sample - Measured substance use at a time when abortion-related stress is likely to be exacerbated	- Compared with women who had previously given birth, women who aborted were significantly more likely to use marijuana (929%), various elicit drugs (460%), and alcohol (122%) during their next pregnancy. Results with only first-time mothers were similar. - Differences between the abortion group and the prior birth and no prior pregnancy groups relative to marijuana and use of any elicit drug were more pronounced among married and higher income women and when more time had elapsed since the prior pregnancy. - Differences relative to alcohol use were most pronounced among the white women and when more time had elapsed since the prior pregnancy.

Publication information	*Comparison groups*	*Data source and sample demographics*	*Outcomes examined*	*Controls*	*Positive methodological Features*	*Results*
5) Cougle, J., Reardon, D. C., & Coleman, P. K. (2003). **Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort.** *Medical Science Monitor, 9,* CR105-112.	First pregnancy event of either an abortion (n=293) or delivery (n=1,591) between 1980 and 1992	**National Longitudinal Survey of Youth** Abortion: Avg. age: 30 Ethnicity: Hispanic: 23% Black: 24% White: 57% Avg. income in 1992: $33,554 Delivery: Avg. age: 30 Ethnicity: Hispanic: 21% Black: 24% White: 55% Avg. income in 1992: $33,969 Avg. of 8 yrs had elapsed since the 1st pregnancy event	- Symptoms of clinical depression	- Prior psych-ological state, age, race, marital status, divorce history, education, and income (stratific-ation by ethnicity, current marital status, and history of divorce)	- Nationally representative, racially - diverse sample - Controlled for prior psychological state and several other variables - Extended time frame	- Women whose 1st pregnancies ended in abortion were 65% more likely to score in the "high-risk" range for clinical depression. - Differences between the abortion and birth groups were greatest among the demographic groups least likely to conceal an abortion (White: 79% higher risk; married: 116% higher risk; 1st marriage didn't end in divorce: 119% higher risk).
6) Coleman, P. K., Reardon, D. C., & Cougle, J. (2002). **The quality of the caregiving environment and child developmental outcomes associated with maternal history of abortion using the NLSY data.** *Journal of Child Psychology and Psychiatry and Allied Disciplines, 43,* 743-758.	Mothers with (n=672) and without a history abortion (n=4,172) prior to childbirth, with children between the ages of 1 and 13 yrs	**National Longitudinal Survey of Youth** Post-abortive: Avg. age: 31 Ethnicity: Hispanic: 25% Black: 31% White: 44% Avg. income in 1992: $30,162 Non post-abortive: Avg. age: 31 Ethnicity: Hispanic: 22% Black: 30% White: 48% Avg. income in 1992: $30,325	- Emotional and Cognitive support in the home - Math, reading, and vocabulary tests - Problems behaviors	- Ethnicity - Marital history - Number of children - Child age and gender - Maternal age, depression, and education - Family income	- One of very few studies to consider the effects of maternal history of abortion on children's behavior and development -Large, nationally representative, racially diverse sample -Extended time frame - Controls for several potentially confounding variables	- Lower emotional support in the home among 1st born 1- to 4-year-olds of mothers with a history of abortion. - When there was a history of abortion, children (2nd & 3rd born. 1 to 4-yr-olds) of divorced mothers experienced lower levels of emotional support than children of non-divorced women. Decreased emotional support was not observed among children of divorced women with no history of abortion. - More behavior problems among 5 to 9-yr-olds of mothers with a history of abortion.

Publication information	*Comparison groups*	*Data source and sample demographics*	*Outcomes examined*	*Controls*	*Positive methodological Features*	*Results*
7) Coleman, P. K., Reardon, D. C., & Cougle, J. (2005) **Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy.** *British Journal of Health Psychology, 10, 255-268.*	Women with a history of abortion (n=280), miscarriage (n=182), and stillbirth (n=30) were compared to women without the respective forms of loss: no miscarriage, n= 221; no abortion, n=144: no stillbirth, n= 371 Comparisons were also made based on pregnancy wantedness	**Washington DC Metropolitan Area Drug Use and Pregnancy Study** Full-sample demographics (1992): Married: 32% Age: 18 or under: 9.3% 19-25: 37.4% 26-34: 40.3% 35 or older: 7.8% Income: Under $10,600: 35% $10,600 - $19,000:16% $19,100 - $30,000:12% $30,100 - $50,000:12% Over $50,000:14% Ethnicity: Black: 79.3%, White: 12.4%, Other:4%	Use of alcohol, illicit drugs, and cigarettes during pregnancy	- Other forms of loss - Age - Marital status - Trimester in which prenatal care was sought -Education -Number in household	- Mostly Black sample (few if any post-abortion studies have focused on this group) - Enabled comparison of various forms of perinatal loss	- No differences were observed in the risk of using any of the substances measured during pregnancy relative to a prior history of miscarriage or stillbirth. - A prior history of abortion was associated with a significantly higher risk of using marijuana (201%), cocaine-crack (198%), cocaine-other than crack (406%), any illicit drugs (180%), and cigarettes (100%). - No differences were observed in the risk of using various substances relative to pregnancy wantedness, with the exception of the risk of cigarette use being higher when pregnancy was not wanted (90%).
8) Reardon, D. C., Coleman, P. K., & Cougle, J. (2004) **Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study.** *Am. Journal of Drug and Alcohol Abuse, 26, 369-383.*	Women with prior histories of delivering an unintended pregnancy (n=535), abortion (n=213), or no pregnancies (n-1144)	**National Longitudinal Survey of Youth** Demographics measured in 1988 Delivery: Married: 66.5%, Avg. age: 26, Avg. income: $22,949 Abortion: Married: 43.7%, Avg. age: 26, Avg. income: $27,076 No pregnancies: Married: 35.4%, Avg. age: 26.3, Avg. income: $29,667. An avg. of 4 yrs since the target pregnancy	Use of marijuana, cocaine, and alcohol	- Age - Ethnicity - Marital status - Income - Education - Pre-pregnancy self-esteem and locus of control	- Nationally representative, racially - diverse sample - Controlled for prior psychological state and other variables - Extended time frame - All women were experiencing an unintended pregnancy	- Compared to women who carried an unintended first pregnancy to term, those who aborted were 100% more likely to report use of marijuana in the past 30 days and 149% more likely to use cocaine in the past 30 days (only approached significance). Women with a history of abortion also engaged in more frequent drinking than those who carried an unintended pregnancy to term. - Except for less frequent drinking, the unintended delivery group was not significantly different from the no pregnancy group

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9) Cougle, J., Reardon, D. C., Coleman, P. K., & Rue, V. M. (2005).**Generalized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth.** *Journal of Anxiety Disorders, 19, 137-142.*	First pregnancy event of either an abortion (n=1,033) or delivery (n=1,813). All were unintended pregnancies	**1995 National Survey of Family Growth** Abortion: Ethnicity: Hispanic: 10%, Black: 26%, White: 61% Avg. income:376% of poverty level Delivery: Ethnicity: Hispanic: 14%, Black: 36%, White: 47% Avg. income: 234% of poverty level Avg. age, both groups: 32. Avg. of 13 yrs since the 1st pregnancy event	Symptoms of Generalized Anxiety Disorder – lasting for a period of at least 6 months.	- pre-existing anxiety, age, and race (stratification by ethnicity, current marital status, and age)	- Nationally representative, racially - diverse sample - Controlled for prior anxiety - Extended time frame - All women were experiencing an unintended pregnancy	- The odds of experiencing subsequent Generalized Anxiety was 34% higher among women who aborted compared to women who delivered. - Differences between the abortion and birth groups were greatest among the following demographic groups: Hispanic 86% higher risk; unmarried at time of pregnancy: 42% higher risk; under age 20: 46% higher risk.
10) Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). **Induced abortion and traumatic stress: A preliminary comparison of American and Russian women.** *Medical Science Monitor* 10, SR 5-16.	Russian (n=331) and U.S. (n=217) women who had experienced one or more abortions and no other forms of loss	Data collected in health care facilities (hospitals, clinics, and physician's offices) by Vincent Rue and colleagues Russian: Avg. age: 28, 59% married, 63% employed full-time U.S.: Avg. age: 34, 49% married, 34% worked full-time An avg. of 5.8 yrs had elapsed since the Russian women's abortions, and 10.6 yrs had elapsed since the U.S. women's abortions	Symptoms of Post Traumatic Stress Disorder	- Severe stress symptoms prior to the abortion - Other stressors pre- and post-abortion - Several demographic variables - Psycho-social variables (harsh discipline, sexual, physical, and emotional abuse, parental divorce, etc.)	- Extensive controls for background variables - One of few cross-cultural comparisons in the literature	- U.S. women reported more stress, PTSD symptoms, and other negative effects than Russian women. - Russian women scored higher on the Pearlman Traumatic Stress Institute Belief Scale, indicating more pronounced disruption of basic needs impacted by trauma (safety, trust, self-esteem, intimacy, and self-control). - No differences relative to perceptions of positive effects (improved partner relationships, feeling better about oneself, relief, feelings of control). - The percentages of Russian and U.S. women who experienced 2 or more symptoms of arousal, 1 or more symptom of re-experiencing the trauma, and 1 or more experience of avoidance (DSM-IV diagnostic criteria) were equal to 13.1% and 65% respectively.

Publication information	*Comparison groups*	*Data source and sample demographics*	*Outcomes examined*	*Controls*	*Positive methodological Features*	*Results*
11) Coleman P, Maxey CD, Rue VM, Coyle CT (2005). **Associations between Voluntary and Involuntary Forms of Perinatal Loss and Child Maltreatment among Low-Income Mothers.** *Acta Paediatrica,94.*	The 518 participants included 118 abusive mothers, 119 neglecting mothers, and 281 mothers with no history of child maltreatment Reproductive loss information: 100 women had a history of one abortion and 99 had a history of one miscarriage/ stillbirth	**Fertility and Contraception Among Low-Income Child Abusing and Neglecting Mothers in Baltimore MD Study** Marital status: Single (78.8%); Separated (18.9%); Married (2.3%). Avg. age: 27. Avg. # of children: 2.64 Ethnicity: Black (79.9%); White (19.7%); Other (4%) Education: >or= 11 years (59%); High school diploma (32%); 13-16 years (9%)	- Child physical abuse - Child neglect	Demographic, personal history, and social variables found to be positively correlated with the forms of child maltreatment examined. - The form of loss not being analyzed	- Use of confirmed cases of child maltreatment - An extended time frame - Diverse sample - Controls for several potentially confounding variables	- Compared to women with no history of perinatal loss, those with 1 loss (voluntary or involuntary) had a 99% higher risk for child physical abuse. - Compared to women with no history of induced abortion, those with 1 prior abortion had a 144% higher risk for child physical abuse. - A history of 1 miscarriage/stillbirth was not associated with increased risk of child abuse. - Perinatal loss was not related to neglect.
12) Coleman, P. K. (2006). **Resolution of Unwanted Pregnancy During Adolescence Through Abortion versus Childbirth: Individual and Family Predictors and Consequences.** *Journal of Youth and Adolescence.*	Adolescents in grades 7-11 who experienced an unwanted pregnancy That was resolved through abortion (n=65) or delivery (n=65)	**National Longitudinal Study of Adolescent Health** Abortion group: 15 to 19 years of age (76.4%); under 15 (23.6%) Parents' marital status: married (51.8%); not married (48.2%) Parental income: under $40,000 (52.8%); $40,000 or more (47.2%) Birth group: 15 to 19 years of age (80.4%); Under 15 (19.6%) Parents' marital status: married (43.6%); not married (56.4%) Parental income: under $40,000 (63.6%); $40,000 or more (36.4%)	- Counseling for emotional problems - Trouble sleeping cigarette smoking - Marijuana use - Alcohol use -Problems with parents because of alcohol use - School problems because of alcohol use	- Demographic, educational, psychological, and family variables found to predict the choice to abort	- Nationally representative, diverse sample -Exclusive focus on unwanted pregnancies - Implemented controls for several potentially confounding variables - Use of two waves of data - longitudinal	- After implementing controls, adolescents with an abortion history, when compared to adolescents who had give birth, were 5 times more likely to seek counseling for psychological or emotional problems, 4 times more likely to report frequent sleep problems, and they were 6 times more likely to use marijuana.

Publication information	*Comparison groups*	*Data source and sample demographics*	*Outcomes examined*	*Controls*	*Positive methodological Features*	*Results*
13) Reardon, D.C., & Coleman, P. K. (2006). **Relative Treatment Rates for Sleep Disorders Following Abortion and Childbirth: A Prospective Record-Based Study.** *Sleep, 29,* 105-106.	15,345 women who had an induced abortion and 41,479 women who delivered and had no known subsequent history of induced abortion while receiving medical assistance from the state of California (Medi-Cal) in 1989 and who had no sleep claims for 1 yr prior to pregnancy resolution. Delivery group had no later abortions	**California Department of Health Services Medi-Cal data** All low–income Delivery: Avg. age: 25 Avg. # of mos. of eligibility: 27 Abortion: Avg. age: 25 Avg. # of mos. of eligibility: 31	Sleep disturbances identified by ICD-9 treatment codes for non-organic sleep disorder and sleep disturbances	- Claims for sleep disorders - Age - Months of eligibility	Used actual claims data, eliminating the concealment problem - Avoids recruitment and retention problems - Eliminated cases with previous sleep claims - With claims data, avoids simplistic forms of assessment - Comparison groups are likely very similar except for the abortion experience - Extended time frame, with repeated measurements enabling more confidence in the causal question	- Women were more likely to be treated for sleep disorders following an induced abortion compared to a birth. -The difference was most pronounced in the first 180 days post pregnancy resolution and was not significant after the third year. Specifically, there was an 85% higher risk for sleep disorders associated with abortion at 180 days and increased risks of 68%, 40%, 41%, and 29% for the 1st year, 2nd year, 3rd year, and across the full 4 year study period respectively.
14) Coleman P, Rue VM, Coyle CT, & Maxey CD (2007). **Induced Abortion and Child-Directed Aggression Among Mothers of Maltreated Children,** *Internet Journal of Pediatrics and Neonatology, 6* (2)	237 mothers who were residents of Baltimore and were receiving AFDC. Women with and without a history of abortion were compared relative to child-directed physical aggression. All the women had a history of child maltreatment	**Fertility and Contraception Among Low-Income Child Abusing and Neglecting Mothers in Baltimore MD Study** Avg. age: 28.4 Avg. # of children: 3.5 Ethnicity: Black 72.2% White: 27.8% Education: >or= 11 years (72%); High school diploma (23%); 13-16 years (5%)	Frequency of throwing objects, shoving, slapping, kicking/biting, hitting, and beating Frequency of physical punishment in general	- Non-voluntary perinatal loss - Socio-demographic, family of origin, and partner aggression variables associated with the choice to abort	- Use of controls - Examined a previously under-investigated segment of the population: predominantly poor, Black women	- Abortion history was associated with significantly more frequent maternal slapping, hitting, kicking/biting, beating, and use of physical punishment in general.

Publication information	*Comparison groups*	*Data source and sample demographics*	*Outcomes examined*	*Controls*	*Positive methodological Features*	*Results*
15) Coleman, P. K., Rue, V., Spence, M., & Coyle, C. (in press). **Abortion and the sexual lives of men and women: Is casual sexual behavior more appealing and more common after abortion?** *International Journal of Clinical and Health Psychology.*	Non-institutionalized U.S. residents, ages 18 to 59. Men and women with and without abortion experience.	**National Health and Social Life Survey (NHSLS)** Among the males sampled 105 (12%) reported having experienced a partner abortion and 767 (88%) did not; whereas among the females, 214 (19.6%) reported having had an abortion and 877 (80.4%) did not. For the full sample, 43% were female and 57% were male. The majority of the respondents were White (71.4%), with 16% Black, 9.4% Hispanic, 1.9% Asian/Pacific Islanders, and 1.2% Native Americans. Education: 14.5% had not graduated from high school, 63% were high school graduates, 15.5% were college graduates, and 6.9% reported an advanced degree.	1) Endorsed appeal of impersonal sexual behaviors (sex with more than one partner, forcing another to have sex, being forced to have sex, watching others have sex, sex with strangers.) 2) Willingness to have sex with someone only if in love. 3) Number of sex partners in the last year. 4) Sexual behavior with a friend and sexual behavior with an acquaintance over the past 12 mos. 5) Impersonal sexual behaviors that occurred at least once in the last 12 months (group sexual activity, sex during a casual encounter, forced sexual activity, payment for sexual activity, and purchasing or renting an x-rated video.)	Controls for family of origin, socio-demographic, reproductive history, and sexual history variables predictive of the choice to abort. Female predictors of abortion: first vaginal intercourse, having lived with both parents at age 14, number of live births, having had a miscarriage, frequency of religious attendance, age. Male predictors of a partner abortion: age left home, educational level attained, partner miscarriage, marital status.	- Use of controls. - Inclusion of men - Large, nationally representative, ethnically diverse sample. - First published study to explore associations between abortion and casual sex.	-Using the female data, abortion was associated with more positive attitudes toward sex with strangers and with being forced to have sex. -With the male data, a partner abortion was associated with attitudes endorsing sex with more than one partner and with strangers. -Both men and women with an abortion experience reported higher levels of disagreement with a statement reflecting willingness to have sex only if in love, reported more sex partners in the last year, and were significantly more likely to have sex with an acquaintance. -Males who experienced a partner abortion were more inclined to have sex with a friend compared to males who never experienced a partner abortion. -An abortion history was associated with a significantly higher likelihood of engagement in specific impersonal sexual behaviors in the previous 12 months: sex during a casual encounter, having forced another to have sex, having been forced by another to have sex among the women sampled. -Engagement in group sex, sex during a casual encounter, having paid for or having been paid for sex, and having purchased or rented an X-rated video were associated with a partner abortion among the males.

Testimony of

Vincent M. Rue, Ph.D.

Before the

Senate Committee on Health,

Human Services, Insurance

and Job Creation

Concerning

Senate Bill 398

Madison, Wisconsin

February 27, 2008

I. Introduction

My name is Vincent M. Rue. I am the Co-Director of the Institute for Pregnancy Loss in Jacksonville, Florida. I have been a practicing psychotherapist for over 30 years specializing in the treatment of trauma and grief associated with induced abortion. I and my colleagues (Drs. Coleman, Reardon, Cougle, Coyle & Shuping) have conducted research and published our results in numerous peer-reviewed medical/psychological journals. I have taught at California State University and lectured widely throughout this country and abroad. I have also consulted with various governmental agencies including the U.S. Surgeon General and the Wisconsin Department of Health and Family Services. I testify today in opposition to SB 398.

It is ironic that prior to the legalization of abortion in 1973, in those states that liberalized their abortion policies, a woman had to justify mental health grounds in order to obtain an abortion. Now with over three decades of experience with legal abortion, the scientific evidence is increasingly clear that abortion places women's mental health at risk, even for those who have never had mental health problems previously.

II. Synopsis of Best Studies

An objective assessment of the psychological effects of induced abortion has been difficult due to underreporting (50-60%), and the stigma and shame attached to having this procedure. Thus, the data that have been available prior to 2002 likely underrepresent the true extent of the adverse emotional consequences of abortion since those most likely to not respond or drop out of studies are those that are more injured (Adler, 1976; Soderberg, Anderson, Janzon, & Sjoberg, 1997). Across the research literature, it is repeatedly reported that approximately 10-30% of women experience significant and lasting adverse post-abortion psychological reactions. The results of the four largest, record-based studies in the world consistently revealed that abortion is associated with increased risk for mental health problems. I was co-author on two of these studies and they are described in Appendix A of this written testimony.

- In the first two studies, we compared over 54,000 low income women who aborted or delivered a child while receiving medical assistance from the state of California in 1989 (Coleman et al, 2002). When we examined outpatient psychiatric claims, we found that within 90 days after pregnancy resolution, the abortion group had 63% more total claims than the birth group, with the percentage equaling 17% across the full 4-year study period. The abortion group had 40% more claims for depression compared to women who delivered. In the 2nd study (Reardon et al., 2003), using inpatient claims, we found overall, women who had an abortion had significantly higher relative risk of psychiatric admission compared with women who had delivered for every time period examined from 90 days post-abortion to four years. These

studies are significant, because in both, controls for prior psychological problems and the focus on low income women were instituted. (see Exhibit A, studies #1& 2)

- In a third study, David et al. (1981) found the overall rate of psychiatric admission was 50% higher for women who aborted compared to those who delivered.

- Finally, in a Canadian study of 80,000 women by Ostbye et al. (2001), health services utilization for psychiatric problems was 165% greater for the women with a history of abortion, compared to those without a history, within 3 months of the procedure.

A recent 25 year longitudinal study by Fergusson et al. (2006) (attached in full in Exhibit B) reported on the psychological outcomes of 1,265 children born in Christchurch NZ in 1977. This research has a number of positive methodological advantages over other studies: (a) it is prospective, following women over many years; (b) it used comprehensive mental health assessments employing standardized diagnostic criteria of DSM III-R disorders; (c) it reported considerably lower estimated abortion concealment rates compared to previously published studies; (d) the sample represented between 80 – 83% of the original cohort of 630 females; and (e) the study used extensive controls.

Fergusson's results have been widely reported throughout the world as an important study on this topic, even challenging the American Psychological Association's position statement. Fergusson et al. found: 42% of the women who aborted reported major depression by age 25, and 39% of post-abortive women suffered from anxiety disorders. In addition, 27% reported experiencing suicidal ideation, 6.8% indicated alcohol dependence, and 12.2% were abusing drugs. Compared to the pregnant/no abortion group, the abortion group scored significantly higher on all these variables except anxiety. Compared to the never pregnant group, the abortion group scored significantly higher on all variables. The findings of this study are consistent with other studies published recently documenting adverse mental health problems associated with elective abortion.

III. Additional Research Evidence

Among the most commonly reported negative psychological effects in the literature are anxiety and depression. Bradshaw and Slade (2003) in an extensive review of the literature "The proportion of women with high levels of anxiety in the month following abortion ranged from 19-27%, with 3-9% reporting high levels of depression. The better quality studies suggested that 8-32% of women were experiencing high levels of distress" (p. 941).

Many women who have aborted experience symptoms of depression including sad moods, sudden and uncontrollable crying episodes, low self-esteem, sleep, appetite, and sexual disturbances.

Guilt associated with abortion has been consistently reported (Broen et al., 2004) and identified in the pre-abortion counseling literature (Baker et al., 1999). I and my colleagues (2004) study revealed that 78% of U.S. women felt guilt in association with a past abortion. (See Exhibit A, #10)

Kero et al. (2001) found that 46% of women who aborted indicated that their thoughts regarding termination evoked a conflict of conscience. The source of such conflict is likely women's understandings of the humanity of the fetus. In Conklin and O'Connor's (1995) study of 800 women who had an induced abortion, those who reported perceiving the fetus as human experienced significantly more post-abortion negative affect and decision dissatisfaction than women who did not. Awareness of the humanity of the fetus is common among women who are seriously contemplating an induced abortion. For example, using semi-structured interviews Smetana and Adler (1979) found that only 25% of women confronting an induced abortion decision understood that the fetus was a human being and understood induced abortion as terminating his or her life. In a recent study conducted by Rue et al. (2004), 50.7 % of American women felt induced abortion was morally wrong. Because of value conflict, ambivalence and guilt are commonly experienced in abortion decision making. Pre-abortion ambivalence is a strong predictor for postabortion mental health decline.

Because abortion is an intentionally caused human death experience, it has been identified in the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders (DSM-III-R) as a type of psychosocial stressor capable of causing posttraumatic stress disorder (PTSD), among other mental disorders (p. 20). In the current version of the DSM, trauma is thus defined:

- "the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others"

- "the person's response involved intense fear, helplessness, or horror" (DSM IV-R, p. 428)

Negative psychological mechanisms to cope with trauma include symptoms of unwanted reexperiencing, symptoms of persistent avoidance and numbing of general responsiveness, as well as persistent symptoms of increased arousal not present before the trauma. These are the hallmark symptoms of PTSD.

Overall, in our trauma-sensitive cross-cultural study we found that American women were more negatively influenced by their abortion experiences than Russian women. While 65% of American women and 13.1% of Russian women experienced multiple

symptoms of increased arousal, re-experiencing and avoidance associated with posttraumatic stress disorder (PTSD), 14.3% of American and 0.9% of Russian women met the full diagnostic criteria for PTSD. (see Exhibit A, #10)

A more recent study by Sulliman et al. (2007) found that 20% of the women who aborted in their sample experienced PTSD 3 months post-procedure. They also found a 61% increase in the number of women experiencing PTSD from one month to three months post-procedure. Additionally, they reported 20% of their sample remained depressed 3 months following the abortion.

Broen, Moum, Bodtker and Ekeberg (2004) found that nearly 17% of 80 women who had an abortion two years earlier scored highly on a scale measuring avoidance symptoms, compared with about 3% of those who miscarried. This was in contrast to responses 10 days after the pregnancy ended, when nearly half of those who miscarried and 30% of those who had an abortion scored high on measures of avoidance or intrusion, which includes symptoms such as flashbacks and nightmares.

The decision to abort is obviously often conflict-ridden with many women seriously questioning their decision and suffering from their choice to abort. Coleman and Nelson (1998) noted that 38.7% of female college students voiced regret in the first few years following an abortion. Moreover, the results of a study by Soderberg and colleagues (1998) indicated that 76.1% of women who had a past abortion would never consider repeating the experience.

IV. Significant Health Risks Associated with Abortion

The risk of death due to suicide is significantly higher among women who abort when compared to those who deliver. Using the Medi-Cal data mentioned a few minutes ago, we found that those who aborted had a 62% higher, age-adjusted risk of death from all causes and a 154% greater risk for death from suicide. The higher death rates associated with abortion persisted over time and may be explained by self-destructive tendencies, depression, and other unhealthy behavior aggravated by the abortion experience. Abortion is a consistent and strong risk factor for suicidal behavior with these findings replicated in other record-linkage studies.

Many studies also support a link between abortion and substance use. Using data from a nationally representative sample, my colleagues and I found that pregnant women with a prior history of abortion, compared to women without a history, were 10 times more likely to use marijuana, 5 times more likely to use various illicit drugs, and were twice as likely to use alcohol. In another paper using a national data set, we found that women who aborted, compared to those who carried an unintended pregnancy to term, were twice as likely to use marijuana and reported more frequent alcohol consumption. (See Exhibit A, #s 4, 7 & 8)

Studies have further shown that abortion is related to an increased likelihood of sexual dysfunction, partner communication problems, and separation or divorce. For example, in a recently published study, we found that 24% of American women sampled reported sexual problems that they directly attributed to a prior abortion. (See Exhibit A, #10 & 15)

Finally, research suggests that emotional difficulties and unresolved grief responses associated with perinatal loss may hinder effective parenting by reducing parental responsiveness to child needs, by interfering with attachment processes, and /or by instilling anger, which is a common component of grief. Two of the studies provided in Exhibit A have linked abortion with compromised parenting. (studies #6 & 14)

V. Benefits of Recent Research since 2002

There are a number of methodological problems associated with previous post-abortion research that my colleagues and I have tried to address in studies published since 2002 (see Exhibit A). Some of the methodological limitations have been:

1) Both recruitment and retention of research subjects in longitudinal investigations have been hurt by the sensitive nature of the topic.

- Initial consent rates are often as low as 50-60%, with drop out rates as high as 60%

- In our studies using Medi-Cal claims, consent and attrition problems were avoided completely.

2) Many studies have been conducted with small samples confined to one geographical locale, restricting the generalizability of findings.

- All our studies used large samples, most in the thousands and several used nationally representative, ethnically diverse samples.

3) Another problem is concealment – approximately 50% of women who have had a previous abortion will deny it.

- Our Medi-Cal studies avoided this problem since medical claims were used.

4) Use of brief, non-standardized measures of psychological health also compromises the integrity of research in this area.

- In the Medi-Cal studies we used medical claims with diagnostic codes assigned by trained professionals.

5) Few relative risk studies have been conducted using appropriate control groups – comparing women who abort to those who carry to term.

- In most of our studies we used women who delivered as a comparison group and in 3 of them *(#s 8, 9, &12 on the handout)* we used women who delivered an unintended pregnancy as the control group.

6) Further, very few studies have utilized controls for pre-existing psychological problems.

- In many of our studies we were able to control for prior psychological problems or state.

7) There have been too few longitudinal Investigations.

- 10 out of 12 of our studies utilized a prospective data collection strategy with repeated assessments over time.

8) Due to multiple intervening factors, it has been difficult to determine the direction of harm.

- most of our studies instituted controls for multiple associated factors

- one of our studies uniquely assessed the degree of injury women attributed to their abortion experience (#10)

VI. Main Findings from Our Studies

The central results from our work are as follows:

First, based on the methodological improvements characterizing the newer studies, prior work indicating that abortion is an emotionally benign medical procedure for most women should no longer be accepted.

Second, in all the analyses conducted, women with a history of abortion were never found to be at a lower risk for mental health problems than their peers with no abortion experience.

Third, the published studies indicate that women with a history of induced abortion are at a significantly higher risk for the following:

- Inpatient and outpatient psychiatric claims, particularly:
  - adjustment disorders
  - bipolar disorder

- depressive psychosis
- neurotic depression, and schizophrenia

- Substance use generally and specifically during a subsequent pregnancy

- Clinically significant levels of depression, anxiety and PTSD

- Relationship and parenting difficulties

- Death by suicide

Fourth, when compared to *unintended pregnancy carried to term,* abortion poses more significant mental health risks.

VII. Rape and Incest Exclusion

Wisconsin's pre-Roe abortion law made no exception for cases involving rape and incest. Rape and incest are highly emotional and inflammatory arguments that have historically contributed towards the liberalization of our abortion laws in this country. When rape and incest are removed from the justifications for abortion, a new perspective is necessary. Such a perspective requires reconsideration of a number of factors.

Rape is a serious and tragic crime against the person. It is often common for even well-meaning, educated and sympathetic individuals to stereotype and categorize the reactions and responses of the rape victim. Often non-victims project themselves into the situation and assume that a sexual assault victim's reaction or a pregnant rape victim's responses will be similar to those they imagine for themselves. These unfortunate stereotypes are not sensitive to the victim and are not helpful.

Consider the following:

- There are approximately 200,000 rapes in the U.S. (reported and unreported) each year and only 2 per 1000 result in pregnancy. This translates out to approximately 400 rape-induced pregnancies in the entire U.S. annually.

- The assumption that pregnant rape victims would naturally want abortions is widespread, but it is not based on the available data.

In one of few studies of pregnant rape victims ever conducted, Mahkorn (1979) found that 85% actually chose *against* abortion.

- There are a number of reasons why women who become pregnant through rape decide not to abort.

    - Many believe it is immoral.
    - Others feel an abortion would be another act of violence against their bodies and their unborn child.
    - Some believe that aborting the unborn child places ultimate control by the perpetrator over the woman and her pregnancy and results in only more re-victimization
    - Still others contend that God or fate would use the child for a greater purpose despite the fact that the child was brought into the world by a horrible act.

- In a second study of 192 women (Reardon et al., 2000), who became pregnant as a result of rape or incest, 88% of women felt abortion was the wrong choice. Forty three percent reported having abortions because of pressure from others and more than 90% said they would discourage other victims of sexual assault from undergoing abortion. Many women reported feeling re-victimized by an abortion.

Pregnant incest victims will often undergo abortions without the abortion provider knowing about the victimization. Most young incest victims are too frightened to reveal their victimization or may believe such sexual contact is a "normal" component of family relationships. Pregnancy may be the sentinel event that leads to a discovery of an incestuous relationship.

The young victim's pregnancy represents a threatening situation for the perpetrator. Unfortunately abortion will frequently be used by the perpetrator or other caretakers to cover up the facts of the victimization. Frequently young incest victims will be coerced into having abortions by those who victimize them or by other caretakers who are dependent on the victimizer. Young victims will often be told to lie about the circumstances of their pregnancy. They may be told that if they reveal their victimization, they will be responsible for breaking up their family, or causing a father, step-father, or other relative to go to jail.

Abortion for a pregnant incest victim solves nothing, and returns her to a life of chronic depression, anxiety and re-traumatization.

After any abortion, feelings of guilt, anxiety, depression, and lowered self-esteem are relatively common and may then accentuate the traumatic feelings associated with sexual assault or incest. After all, if one trauma follows from another, it is entirely reasonable to assume that the former cannot remediate the latter. Clinical research evidence is clear that this does not occur.

VIII. Conclusion

The findings reported today indicate that it is false and misleading to suggest to women that abortion has no significant mental health risks, much less is "psychologically safer" than carrying to term.

Women facing an unwanted pregnancy often feel desperate and alone, fearing loss of their personal autonomy, destruction of their plans for the future, loss of others' esteem, and altered relationships in addition to viewing a baby as an enormous responsibility that they are ill-prepared to assume. In such circumstances, women need real and considerable support, not the simple "solution" that an abortion promises.

Because women are urged to make their decision quickly, many may fail to realize how their decision to abort may significantly compromise the quality of their lives for many years beyond the decision. The many life enhancing aspects of having a child are certainly not discussed or encouraged at abortion clinics. Hence, if women are offered either no information as identified herein or misinformation based upon ideology and profit-based motives, their mental health can be placed in harm's way.

The psychological health risks for women who abort are greater than for those who carry to term an unwanted pregnancy. If you cast your vote in opposition to SB 398, you are voting in conjunction with sound scientific knowledge and preventing women's mental and physical health from needlessly being placed at risk.

I urge you to vote against SB 398. Thank you.

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Testimony in Support of the Women's Health & Safety Act (SB 398)
Representative Terese Berceau
February 27, 2008

Wisconsin is currently one of four states that continue to have a pre-*Roe v. Wade* abortion ban in its statutes. Along with Delaware, Alabama and Massachusetts, if the U.S. Supreme Court were to overturn *Roe v. Wade*, Wisconsin would automatically make abortion a crime. There would be no further legislative or judicial action needed and district attorneys could start prosecuting immediately. As if this prospect is not troubling enough, Wisconsin also has the distinction of being the only state in the country that's criminal abortion law contains penalties for women who obtain abortions, including for women who are the victim of rape, incest and whose health is endangered. Such archaic thinking is unacceptable in this day and age. It is time to repeal this dangerous and outdated law now.

I, along with Senator Mark Miller, introduced the Women's Health and Safety Act to remove this law from our books once and for all. In light of the greatly diminishing federal protections for women's health in the reproductive context, the only way to ensure that a woman is NEVER prosecuted in Wisconsin for obtaining an abortion is to remove 940.04 from our statutes. Can you imagine, women being brought to trial for obtaining an abortion necessary to protect her health? Or a woman on trial for seeking an abortion after a brutal assault? I'd like to share with you a story from a Wisconsin woman who wanted to be here today to support the women's health and safety act. Her name is Linda Gage and she currently lives in Eau Claire. When she was a young women, Linda was brutally raped. Here is her story:

> **When I was 18, I was raped. The perpetrator raped me, beat me and left me to die on the side of the road. I went to the police, and they didn't even take the person's name. I went to the hospital. They didn't do a complete medical exam. They just cleaned up my bruises and scrapes and sent me home.**
>
> **I am the mother of three daughters. I am speaking out today because it is too painful to think about one of my daughters, or any other woman, going through what I went through.**
>
> **It is even more unimaginable to think that a rape victim who chose to have an abortion after being brutally attacked could be thrown in jail under our current statute. These women are your mothers, your sisters, your daughters. Your friends. They are not, and should not, be treated as criminals. That is why I support the Women's Health and Safety Act.**

This bill is so very important because no woman should fear criminal prosecution for making a health care decision—but especially women like Linda, who may have suffered great traumas that result in a forced pregnancy. These women should be protected by our legal system, not treated like criminals.

Opponents of my bill, mainly Wisconsin Right to Life, tout the fact that after Roe v. Wade's reversal Wisconsin will be the first state in the country to outlaw abortion. As long as sec. 940.04 remains on the books, they are absolutely correct. But I have to ask you, is this a Wisconsin that we as a community want to see? The bottom line is that when abortion is illegal, women die. Abortion does not go away when the government bans it, rather it goes underground. In the U.S., while abortion rates are consistently dropping we continue to have some of the highest abortion rates in the developed world. Banning abortion will not diminish these numbers. All we have to do is look at the 69 countries world wide where abortion is prohibited. According to the World Health Organization, approximately 70,000 women world wide die from unsafe abortions every year, almost all of them in countries where abortion is illegal. Women in Wisconsin should never be forced to return to illegal, back-alley abortions.

I do want to acknowledge here that Wisconsin law regarding sending women to prison for obtaining an abortion is conflicted. We have the criminal abortion statute, sec. 940.04, that provides criminal penalties for women. We also have a law that was passed in 1985, sec. 940.13 that states no fine or imprisonment may be enforced against a woman for obtaining an abortion. Which law controls then? When Roe v. Wade is overturned, how will a district attorney decide which law to proceed under? The only answer to that question exists in the courts, they will ultimately decide. The only way to ensure that no court uses its discretion to lock women up is to repeal this law now.

The only way physicians will not be thrown in jail for performing abortions, including in instances of rape or incest, is to get rid of this statute. Locking up physicians who provide safe, legal abortions will leave women without any options even in the most tragic circumstances. We will once again see the return to back alley abortions and to women dying.

In fact, during this debate over the last two legislative sessions, no one has explained to me a valid reason why we should keep this outdated law on the books. Repealing the criminal abortion law will not affect any of our existing abortion restrictions. Abortion will still be illegal after viability. Women will still be forced to listen to state-directed counseling and wait an additional 24 hours after that counseling before obtaining an abortion. Young women will still be required to obtain parental consent. Poor women will still be unable to access abortion services through the Medicaid program. All of these restrictions will remain intact. The only thing that the Women's Health and Safety Act will accomplish is to remove the criminal penalties for women and doctors who obtain or provide abortion services prior to fetal viability. Repealing this law now is the only way to ensure that no woman or physician ever goes to prison in Wisconsin for making a health care decision. Period. That seems like a good enough reason to me.

WISCONSIN CATHOLIC CONFERENCE

TESTIMONY REGARDING SENATE BILL 398: ABORTION BAN REPEAL
Presented to the Senate Health and Human Services Committee
February 27, 2008

My name is Barbara Sella and I am the Associate Director for Respect Life and Social Concerns at the Wisconsin Catholic Conference. On behalf of Wisconsin's Roman Catholic bishops, I strongly urge you to oppose Senate Bill 398, which would repeal our state's abortion ban.

Laws do more than prohibit certain behaviors. The law is also a teacher, helping a community attain its highest aspirations. Wisconsin's abortion ban reflects our state's progressive and humanitarian tradition that all human beings – whether born or unborn – deserve to be treated with equal respect.

Over the past century, Wisconsin led the nation in protecting the vulnerable from exploitation. Reforms such as child labor laws, the minimum wage, the creation of child welfare programs, civil rights laws, and family leave laws have all increased the protection of groups that otherwise risked being harmed by the more powerful.

On the day that *Roe v. Wade* is overturned, Wisconsin will once again be at the forefront of states that protect the most vulnerable of all – the unborn.

Let me be equally clear as to what will not happen when *Roe* is overturned. Women who have abortions will not be put in jail. For the enforcement of s. 940.04 will not repeal s. 940.13, which protects women who abort from prosecution.

The WCC fully supports s. 940.13. The aborted child is not the only victim of an abortion. Women are also victims and they deserve compassion, not incarceration.

According to the most recent statistics on induced abortions ("Facts on Induced Abortion in the United States," Guttmacher Institute, January 2008) in 2005, half of all induced abortions were obtained by women under the age of 25. A woman living below the federal poverty level was four times more likely to obtain an abortion than a woman living at 300% of the poverty level. Two-thirds of all abortions were obtained by unmarried women. African-American women and Latino women were 4.8 and 2.7 times more likely to get an abortion than White women. Three-quarters of women who aborted said they could not afford to care for a child.

In short, abortion is most prevalent among young, poor, unmarried women, with the highest rates among women of color. These are individuals who feel compelled to obtain an abortion because they do not have sufficient economic or emotional support.

-over-

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Catholic teaching holds that the solution to poverty and illegitimacy is not abortion, but love and responsibility, justice and solidarity. Women and their unborn children deserve the right not only to a safe birth, but also to a safe and dignified life – to sufficient nutrition, housing, education, health care, and employment. These issues should be the focus of our public policy efforts, not the defense of abortion.

In 1973, some believed that legalized abortion was the way to a more just society. Today we know better. In the 35 years since *Roe v. Wade*, out-of-wedlock births have steadily increased. Child neglect persists. Ninety per cent of all fetuses diagnosed with Down Syndrome are aborted. Women and men suffer psychological and physical harm from their past abortions. Millions of unborn children have lost their lives.

To accept abortion on demand is to accept these injustices. It is to accept that we are <u>not</u> created equal, and that some human lives have greater moral worth than others. It is to accept that human lives conceived out-of-wedlock, or with fetal abnormalities, are less entitled to our respect. It is to accept that a human life is only precious if it is wanted by somebody else.

This logic is not simply unjust – it defies reason. The basic premise of a democratic society is the equal rights of all its members. Our nation's Founders affirmed that our Creator endows every human life with intrinsic and inalienable dignity. Lincoln reaffirmed this at Gettysburg. We can reaffirm it today by leaving s. 940.04 in our state statutes.

Thank you.

GUTTMACHER INSTITUTE

In Brief

Facts on Induced Abortion In the United States

INCIDENCE OF ABORTION

• Nearly half of pregnancies among American women are unintended, and four in 10 of these are terminated by abortion. Twenty-four percent of all pregnancies (excluding miscarriages) end in abortion.

• In 2002, 1.29 million abortions took place, down from 1.36 million in 1996. From 1973 through 2002, more than 42 million legal abortions occurred.

• Each year, two out of every 100 women aged 15–44 have an abortion; 48% of them have had at least one previous abortion.

• About half of American women have experienced an unintended pregnancy, and at current rates more than one-third will have had an abortion by age 45.

WHO HAS ABORTIONS

• Fifty-two percent of U.S. women obtaining abortions are younger than 25: Women aged 20–24 obtain 33% of all abortions, and teenagers obtain 19%.

• Black women are almost four times as likely as white women to have an abortion, and Hispanic women are 2.5 times as likely.

• Forty-three percent of women obtaining abortions identify themselves as Protestant, and 27% as Catholic.

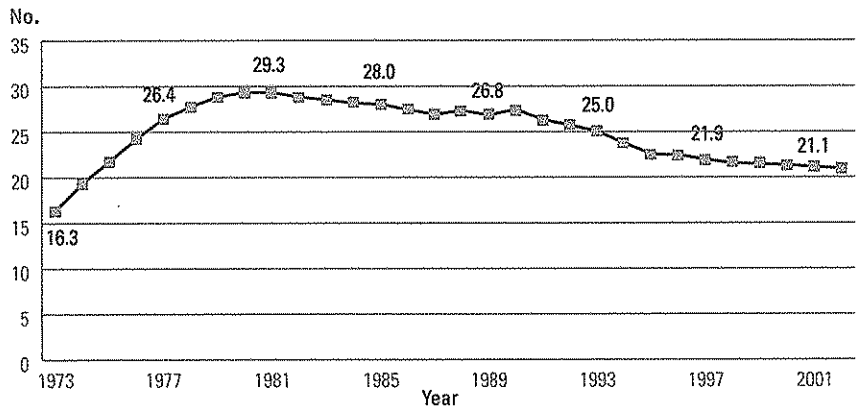
• Two-thirds of all abortions are among never-married women.

• Over 60% of abortions are among women who have had one or more children.

• The abortion rate among women living below the federal poverty level ($9,570 for a single woman with no children) is more than four times that of women above 300% of the poverty level (44 vs. 10 abortions per 1,000 women).

• On average, women give four reasons for choosing abortion. Three-fourths of women cite concern for or responsibility to other individuals; three-fourths say they cannot afford a child; three-fourths say that having a baby would interfere with work, school or the ability to care for dependents; and half say they do not want to be a single parent or are having problems with their husband or partner.

Number of abortions per 1,000 women aged 15–44, by year



CONTRACEPTIVE USE

• Fifty-four percent of women having abortions used a contraceptive method during the month they became pregnant. Among those women, 76% of pill users and 49% of condom users reported using their method inconsistently, while 13% of pill users and 14% of condom users reported correct use.

• Forty-six percent of women having abortions did not use a contraceptive method during the month they became pregnant. Of these women, 33% perceived themselves to be at low risk, 32% had concerns about contraceptive methods, 26% had unexpected sex and 1% were forced to have sex.

• Eight percent of women having abortions have never used a method of birth control; nonuse is greatest among those who are young, poor, black, Hispanic or less educated.

• About half of unintended pregnancies occur among the 11% of women at risk of unintended pregnancy who did not use contraceptives in the month they became pregnant. Most of these women had practiced contraception in the past.

PROVIDERS AND SERVICES

• The number of U.S. abortion providers declined by 11% between 1996 and 2000 (from 2,042 to 1,819). Eighty-seven percent of all U.S. counties lacked an abortion provider in 2000. These counties were home to 34% of all 15–44-year-old women.

• Thirty-seven percent of providers offer abortion at four weeks' gestation, and

97% offer abortion at eight weeks. Thirty-three percent offer abortion at 20 weeks, after which the number of providers offering abortion services drops off sharply. Only 2% of all abortion providers provide abortions at 26 weeks' gestation.

• The proportion of providers offering very early abortion (at four weeks' gestation) increased from 7% in 1993 to 37% in 2001.

• In 2001, the cost of a nonhospital abortion with local anesthesia at 10 weeks' gestation ranged from $150 to $4,000, and the average amount paid was $372.

MEDICATION ABORTION

• In September 2000, the U.S. Food and Drug Administration approved the abortion drug mifepristone to be marketed in the United States as an alternative to surgical abortion.

• In nonhospital facilities offering mifepristone for use in medication abortion in 2001, the average cost of a medication abortion was $490.

• At one large network of providers, the proportion of early abortions performed with mifepristone increased from 9% of eligible women in 2001 to 24% in 2004.

SAFETY OF ABORTION

• The risk of abortion complications is minimal; fewer than 0.3% of abortion patients experience a complication that requires hospitalization.

• Abortions performed in the first trimester pose virtually no long-term risk of such problems as infertility, ectopic pregnancy, spontaneous abortion (miscarriage) or congenital malformation (birth defect), and little or no risk of preterm or low-birth-weight deliveries.

• Exhaustive reviews by panels convened by the U.S. and British governments have concluded that there is no association between abortion and breast cancer. There is also no indication that abortion is a risk factor for other types of cancer.

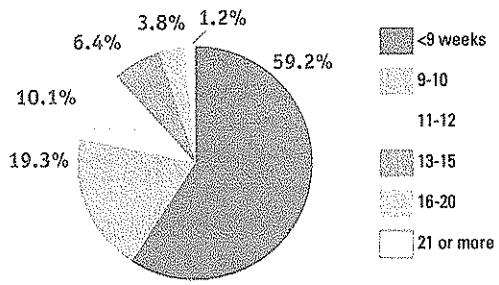
• In repeated studies since the early 1980s, leading experts have concluded that abortion does not pose a hazard to women's mental health.

• The risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks to one per 29,000 at 16–20 weeks—and one per 11,000 at 21 or more weeks.

• The risk of death associated with childbirth is about 12 times as high as that associated with abortion.

When women have abortions (in weeks)

Eighty-eight percent of abortions occur in the first 12 weeks of pregnancy, 2001.



• Fifty-eight percent of abortion patients say they would have liked to have had their abortion earlier. Nearly 60% of women who experienced a delay in obtaining an abortion said it was because of the time it took to make arrangements and raise money.

• Teens are more likely than older women to delay having an abortion until after 15 weeks of pregnancy, when the medical risks associated with abortion are significantly higher.

LAW AND POLICY

• In the 1973 *Roe v. Wade* decision, the Supreme Court ruled that women, in consultation with their physician, have a constitutionally protected right to have an abortion in the early stages of pregnancy—that is, before viability—free from government interference.

• In 1992, the Court reaffirmed the right to abortion in *Planned Parenthood v. Casey*. However, the ruling significantly weakened the legal protections previously afforded women and physicians by giving states the right to enact restrictions that do not create an "undue burden" for women seeking abortion.

• Thirty-four states currently enforce parental consent or notification laws for minors seeking an abortion. The Supreme Court ruled that minors must have an alternative, such as the ability to seek a court order authorizing the procedure.

• Even without specific parental involvement laws, six in 10 minors who have an abortion report that at least one parent knew about their procedure.

• Congress has barred the use of federal Medicaid funds to pay for abortions, except when the woman's life would be endangered by a full-term pregnancy or in cases of rape or incest.

• Seventeen states do use public funds to pay for abortions for some poor women, but only four do so voluntarily; the rest do so under a court order. About 13% of all abortions in the United States are paid for with public funds (virtually all from state governments)

• Family planning clinics funded under Title X of the federal Public Health Service Act have helped women prevent 20 million unintended pregnancies over the last 20 years. An estimated nine million of these pregnancies would have been expected to end in abortion.

The data in this fact sheet are the most current available. Most are from research conducted by the Guttmacher Institute and/or published in its peer-reviewed journals. An additional source is the Centers for Disease Control and Prevention.

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June/2006

Teen Abortion Risks
Fact Sheet

"Parents are faced with a shell of a person and have no idea where they lost their child."
—Terri, who had a secret abortion as a teen

Suicide attempts – 6 times more likely

- **Teenagers are 6 times more likely to attempt suicide if they have had an abortion in the last six months** than are teens who have not had an abortion.[1]
- **Teens who abort are up to 4 times more likely to commit suicide than adults who abort**,[2] and a history of abortion is likely to be associated with adolescent suicidal thinking.[3]
- **Overall suicide rates are 6-7 times higher among women who abort.**[4]
- **Teens who abort are more likely to develop psychological problems**,[5] and are nearly three times more likely to be admitted to mental health hospitals than teens in general.[6]
- **About 40% of teen abortions take place with no parental involvement**,[7] leaving parents in the dark about subsequent emotional or physical problems.
- **Teens risk further injury or death because they are unlikely to inform parents of any physical complications.** Some examples of teens who died from complications or suicide after they had abortions without telling their parents:[8]

  Holly Patterson, California, died at age 18
  Dawn Ravanell, New York, died at age 13
  Sandra Kaiser, St. Louis, died at age 14 of suicide
  Erica Richardson, Maryland, died at age 16
  Tamia Russell, Detroit, died at age 15

  Sandra died 3 weeks after her half-sister took her for an abortion without telling Sandra's mother, who could have warned doctors about Sandra's history of psychological problems that put her at risk for more problems after abortion.[9]
- **Teens are 5 times more likely to seek subsequent help for psychological and emotional problems** compared to their peers who carry "unwanted pregnancies" to term.[10]
- **Teens are 3 times more likely to report subsequent trouble sleeping, and nine times more likely to report subsequent marijuana use after abortion.**[10]
- **Among studies comparing abortion vs. carrying to term, worse outcomes are associated with abortion,** even when the pregnancy is unplanned.[10]
- **65% higher risk of clinical depression among women who abort.**[11]
- **65% experienced multiple symptoms of Post-Traumatic Stress Disorder (PTSD) among women who abort.**[12]
- **64% of women who had undergone an abortion reported that they felt pressured by others to abort.**[12]

Acute Pain. Infertility. Risk of Death.

- **Acute pain**
  Teens report more severe pain during the abortion procedure vs. adult women. One study of pain during 1st trimester abortions found severe acute pain comparable to childbirth or cancer. Pain scores were significantly higher for teens.[13]
- **Lacerations up to twice as likely**
  Teens are up to twice as likely to experience dangerous cervical lacerations during abortion compared to older women,

continued ▸

probably because they have smaller cervixes which are more difficult to dilate or grasp with instruments.[14]

- **Infertility and life-threatening complications**
  Teens are at higher risk for post-abortion infections such as pelvic inflammatory disease (PID) and endometritis because their bodies are more susceptible to infection and they are less likely than older women to follow instructions for medical care.[15] These infections increase their risk of infertility, hysterectomy, ectopic pregnancy, and other serious complications.[16]

- **Breast cancer risk 30-50% higher**
  An early full-term birth reduces breast cancer risk by as much as 1/3, while abortion of a first pregnancy carries a 30- to 50% increased risk of breast cancer.[17] More than 90% of those who abort at 17 or younger have not had a previous full-term pregnancy, compared to 78% of patients age 18-19 and 49% of abortion patients overall.[18]

- **Teens more likely to abort because of pressure from their parents or partner**[19]

- **Teens more likely to report being misinformed in pre-abortion counseling**[20]

Teens more likely to have riskier late-term abortions

According to the CDC, approximately 30% of abortions among teens take place at 13 weeks gestation or greater, compared to only 12% among women in general.[21] Late-term abortions are associated with ...

- **More severe psychological complications**
  This is often because the woman wants to continue the pregnancy but ends up aborting because of pressure from others or her circumstances.[22] Women who have 2nd-trimester abortions are more likely to express ambivalence, regret, moral or religious objections, and to have a more favorable attitude toward the unborn child than women having 1st-trimester abortions.[23]

- **Higher risk of serious physical complications**
  Teens who abort in the 2nd and 3rd trimester face a greater risk of physical complications, including endometritis, intrauterine adhesions, PID, subsequent miscarriages, ectopic pregnancies, ruptured uterus, and death.[24]

- **Trouble with later pregnancies for mother and baby**
  D&E abortions, frequently used in the second trimester, are associated with low birth weight in later pregnancies, which can lead to health and developmental problems for the baby, including cerebral palsy.[25]

Grief, trauma and self-destructive outcomes

- **Teens who abort are twice as likely as their peers to abuse alcohol, marijuana, or cocaine.**[26]

- **Teens have greater difficulty coping** after abortion,[27] leading to problems such as suicide, psychological problems, substance abuse, and difficulty in relationships

- **Negative effects on relationships and parenting.** Teens who report "being particularly fond of children" do not do as well psychologically after an abortion.[28] Teenagers who have abortions often have problems regarding sexuality and parenting later in life.[29]

- **A lonely, traumatic experience.** The abortion procedure itself is considered by many teenagers to be stressful and associated with feelings of guilt, depression, and a sense of isolation.[30]

- **A nightmare that doesn't end.** Teens are more likely to report severe nightmares and to score higher on scales measuring antisocial traits, paranoia, drug abuse, and psychotic delusions than are older abortion patients.[31]

- **Four times higher risk of repeat abortion.** Teens who abort are likely to become pregnant again within the next few years.[32] Among pregnant teens, those who had had an abortion were at least 4 times more likely to abort.[33]

For additional information on post-abortion research and links to published studies, visit **www.afterabortion.org**

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Recent Research
Abortion's Harm to Women

1. **62% Higher Risk of Death from All Causes, 2.5 Times Higher Risk of Suicide**

Compared to women who give birth, women who abort have an elevated risk of death from all causes, which persists for at least eight years. Higher risk of death from suicide and accidents were most prominent. Projected on the national population, this effect may contribute to 2,000 - 5,000 more deaths among women each year.[1]

Southern Medical Journal, 2002

2. **3.5 Times Higher Death Rates from Suicide, Accidents, Homicides (Suicide 6 Times Higher)**

Researchers examining deaths among the entire population of women in Finland found that those who had abortions had a 3.5 times higher death rate from suicide, accidents, or homicides in the following year. Suicide rates among aborting women were six times higher compared to women who gave birth and two times higher compared to women who miscarried.[2]

European Journal of Public Health, 2005

3. **Abortion Deaths Underreported on Death Certificates**

A study of medical records in Finland found that 94 % of maternal deaths associated with abortion are not identifiable from death certificates alone. The researchers found that linking death certificates to medical records showed that the death rate associated with abortion is three times higher than that associated with childbirth.[3]

Paediatric Perinatal Epidemiology, 2004

4. **65% Suffered Trauma, 31% Had Health Complications**

In this study comparing American and Russian women who had experienced abortion, 65% of American women studied experienced multiple symptoms of post-traumatic stress disorder (PTSD), which they attributed to their abortions. Slightly over 14% reported all the symptoms necessary for a clinical diagnosis of abortion induced PTSD, and 84% said they did not receive adequate counseling.[4] 31% had health complications afterward.

Medical Science Monitor, 2004

5. **64% Involve Coercion, 84% Not Fully Informed**

In the above study comparing American and Russian women who had experienced abortion, 64% of American women reported that they felt pressured by others to abort.[5] 84% said they did not receive adequate counseling.[4]

Medical Science Monitor, 2004

6. **Higher Rates of Depression, Substance Abuse, Suicidal Behavior After Abortion**

In a New Zealand study, women who had abortions subsequently experienced higher rates of substance abuse, anxiety disorders, and suicidal behavior than women who had not had abortions, even after controlling for pre-existing conditions. Approximately 42% of women with a history of abortion had experienced major depression in the last four years (nearly double the rate of women who had not been pregnant and 35% higher than those who carried to term).[6]

Journal of Child Psychology and Psychiatry, 2006

7. **Significantly Higher Risk of Clinical Depression**

Compared to women who carry their first unintended pregnancies to term, women who abort their first pregnancies are at significantly higher risk of clinical depression as measured an average of eight years after their first pregnancies.[7]

British Medical Journal, 2002

continued ▸

8. 65% Higher Risk of Clinical Depression

Analysis of a federally funded longitudinal study of American women revealed that women who aborted were 65% more likely to be at risk of long-term clinical depression after controlling for age, race, education, marital status, history of divorce, income, and prior psychiatric state.[8]

Medical Science Monitor, 2003

9. 30% Higher Risk of Generalized Anxiety Disorder

Researchers compared women who had no prior history of anxiety and who had experienced a first, unintended pregnancy. Women who aborted were 30% more likely to subsequently report all the symptoms associated with a diagnosis for generalized anxiety disorder, compared to women who carried to term.[9]

Journal of Anxiety Disorders, 2005

10. Five Times Higher Risk of Substance Abuse

Women who abort are five times more likely to report subsequent drug or alcohol abuse than women who deliver.[10]

American Journal of Drug and Alcohol Abuse, 2000

11. Unintended First Pregnancies: Increased Substance Abuse if Women Abort

Among women who had unintended first pregnancies, those who had abortions were more likely to report, an average of four years later, more frequent and recent use of alcohol, marijuana, and cocaine than women who gave birth. This is the first study to compare substance abuse rates among women who had unintended pregnancies.[11]

American Journal of Drug and Alcohol Abuse, 2004

12. Nearly Twice as Likely to Be Treated for Sleep Disorders, Which Are Often Trauma-Related

In a record based study of nearly 57,000 women with no known history of sleep disorders, women were more likely to be treated for sleep disorders after having an abortion compared to giving birth. Aborting women were nearly twice as likely to be treated for sleep disorders in the first 180 days after the pregnancy ended compared to delivering women. Numerous studies have shown that trauma victims will often experience sleep difficulties.[12]

Sleep, 2006

13. Records-Based Study Indicates More Outpatient Psychiatric Care

Analysis of California Medicaid records shows that women who have abortions subsequently require significantly more treatments for psychiatric illness through outpatient care.[13]

American Journal of Orthopsychiatry, 2002

14. 160% More Likely to be Hospitalized for Psychiatric Treatment

A review of the medical records of 56,741 California Medicaid patients revealed that women who had abortions were 160% more likely than delivering women to be hospitalized for psychiatric treatment in the first 90 days following abortion or delivery. Psychiatric treatment rates remained significantly higher for at least four years.[14]

Canadian Medical Association Journal, 2003

15. Screening for Known Risk Factors Would Dramatically Reduce Abortions

This study is an analysis of 63 medical studies that identify risk factors that predict negative psychological reactions to abortion. The review concludes that the number of women suffering from negative emotional reactions to abortion could be dramatically reduced if abortion clinics screened women for these risk factors.[15]

The Journal of Contemporary Health Law and Policy, 2004

16. Subsequent Children Are Negatively Affected

The children of women who had abortions have less supportive home environments and more behavioral problems than children of women without a history of abortion. This finding supports the view that abortion may negatively affect bonding with subsequent children, disturb mothering skills, and otherwise impact a woman's psychological stability.[16]

Journal of Child Psychology and Psychiatry, 2002

17. Drug Abuse During Subsequent Pregnancies Five Times More Likely

Among women delivering their first pregnancy, women with a history of abortion are five times more likely to use illicit drugs and two times more likely to use alcohol *during* their pregnancies. This substance use places their unborn children at risk of birth defects, low birth weight, and death.[17]

American Journal of Obstetrics and Gynecology, Dec. 2002

18. Increased Smoking and Drug Abuse During Subsequent Pregnancies

A study of women who had just given birth found that compared to women who had experienced other types of pregnancy loss or had never had an abortion, women who had previously had an abortion are more likely to smoke, drink alcohol, or use marijuana, cocaine, or other illegal drugs during pregnancy.[18]

British Journal of Health Psychology, 2005

19. 95% Want To Be Fully Informed of All Statistically Associated Risks

Women considering elective surgery, such as abortion, consider all information about physical or psychological risks to be very relevant to their decisions. Fully 95 percent of patients wished to be informed of all risks statistically associated with a procedure, even if the causal connection between the procedure and risk has not been fully proven. (This finding is especially relevant to abortion providers who assert that, without proof that abortion directly causes problems such as depression or breast cancer, women would prefer not to be given such "worrisome" and "unnecessary" information.)[19]

Journal of Medical Ethics, 2006

20. Teens Have More Mental Health Problems After Abortion, Even With Unplanned Pregnancies

A nationally representative study found that aolescent girls who abort unintended pregnancies are five times more likely to seek subsequent help for psychological and emotional problems compared to their peers who carry unintended pregnancies to term, after controlling for previous mental health history, family situations and other factors that might influence mental health. Teens who aborted were also three times more likely to report having trouble sleeping and nine times more likely to report subsequent marijuana use. [20]

Journal of Youth & Adolescence, 2006

21. Abortion Increases Risk of Later Miscarriage by 60%

Researchers in the U.K. surveyed women ages 18 to 55 about their reproductive histories, lifestyles and relationships and found that women who had a previous abortion had a 60 percent higher risk of miscarriage during a subsequent preganancy.[21]

BJOG: An International Journal of Obstetrics & Gynecology, 2006

The Elliot Institute was involved in many of the studies listed above. For more comprehensive information, including links to some of the published studies, visit **www.afterabortion.org/news.**

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My name is Hallie Wiertzema. I am a wife, a mother, and a nurse from Richland County and I am testifying in opposition to Senate Bill 398. I am in favor of preserving Statute 940.04 in Wisconsin's Law and I'll tell you why.

The ways that the issue of abortion has affected me are multifaceted, much like that of a diamond. I grew up in a loving home always aware that I was adopted. Mom and Dad told me often I was special-because they picked me. I experienced a very normal childhood, filled with more positive experiences than any child could imagine.

In April 1999, my parents drove with me to meet my biological parents. It was a wonderful reunion and there has been continued relationship. Families on both sides have embraced me and included me in many ways, like, weddings, holiday gatherings, birthday parties and family reunions.

In May 1999, the State Department released my impounded Birth Certificate. It was the reading of that document that has changed my life's focus and desires. The story spoke of a teenage girl who had gone to her family doctor to get an abortion. Her father had sent her away and told her not to come home until she had an abortion.

The doctor was kind and wanted to help so he looked at getting a plane ticket to New York to have an abortion there. But, a quick ultrasound check showed the baby was too far developed to abort so that doctor took $1600 out of his own personal money to give her food and a place to live. He delivered that baby and had the baby placed for adoption. And that baby was me.

It's very humbling to read an account of your life, especially of your beginning and realize that you almost weren't here. I have

met the nurse who delivered me and also have been in contact with the Doctor who ultimately saved my life.
This leads me to facet two on my diamond.

My parents encouraged me to WAIT to experience sex within marriage. I held this deep conviction, as well, especially as I watched two of my high school friends experience childbirth in their freshman year. Some of my friends talked about STD's they had gotten, while others suffered the aftereffects of choosing to abort their babies. I was well on my way to achieving my goals and avoiding these issues.

Two weeks away from my High School graduation I attended a post-prom party. You see, my date and I were elected the King and Queen the year before. So, we attended the prom the next year to crown the new King and Queen. Back at the post-prom party, there was a lot of fun, food, friends, and other poor choices that enabled my virginity to be taken from me in a date-rape situation.

I've often heard that abortion is the "the compassionate choice" in cases of rape or incest. I disagree with that, let me tell you why.

When I was nineteen and attending UW-Madison I faced an unintended pregnancy. My boyfriend said he would support whatever decision I made. Pursuing a career at the time, I thought it would best for everybody involved if I just had an abortion. Ultimately, that's what we chose and I can honestly say that it was the worst decision I've ever made.

I'm 36 today and I would have a 17 year old child if I had not made a decision based out of fear and selfishness. Many times people say, "yes, but if you were raped then abortion would be O.K." Or, "it would be just too difficult to have the child around as a reminder of that rape. Abortion would be acceptable then." I believe the pain of being raped is much less than the pain of

abortion because you don't have a choice in the matter. Whereas, the emotional impact of having an abortion is greater because you, yourself, make a choice to kill your baby. In my experience, the physical pain of an abortion is much greater than that of rape. Abortion is NOT a painless procedure.

This leads me to facet three on my diamond. Prior to my abortion, I was a pretty motivated person on my way toward a career in nursing and hospital management. I enjoyed long distance running and my friendships. I basically enjoyed my life!!

After my abortion, I lost sight of my goals. Symptoms of anxiety, depression, thoughts of ending my life, continuous guilt, sleeplessness, lack of motivation, and profound sadness, clouded in. Opponents may disagree that Post Abortion Syndrome in Women exists. But I ask, how is it that a person could be so contented, motivated, and happy with the first 19 years of their life, and with a 20 minute abortion procedure have feelings so completely opposite for the next 10 years...

I believe the emotional impact of having an abortion is far-reaching. Facet four on my diamond is the study I went through 6 years ago to deal with the issues and overcome Post-abortion syndrome. The study was called Forgiven and Set Free and it did just that!! I have led other women through the study and their tears and remorse are replaced with a joy for living again. My past boyfriend said there hasn't been a day that goes by where he doesn't think about that baby and what life could've been like. Men, also, are affected by abortion.

This leads me to conclude with facet five on my diamond. I am grateful to the Doctor who courageously stood up and gave me the Right to Life, Freedom and the Pursuit of Happiness. Where is our nation headed as 48 million people have been denied these basic rights according to our Constitution. How long will we have

to wait for our leaders to step up and say abortion practices need to stop??

What is the value of a life?? Ask my husband of nearly 3 years; ask my family and friends, ask my patient after I've adjusted his ventilator settings, ask the young people I get to talk with about Saving themselves for marriage, ask the 1 in 4 women you pass by in public who've just had an abortion.

I'm so glad that Doctor stepped up and gave me the opportunity to live and experience the love of my husband and children; the kisses of my 2 year old and his voice echoing mama.

Members of this committee, I hope that you remember my stories because, like me, it may well be YOUR daughter, sister-in-law, aunt, wife, or grandma whom abortion touches. I appreciate your vote against Senate Bill 398 and to SAVE s. 940.04 Thank-you!!

940.04

940.04 Abortion.

940.04(1)

(1) Any person, other than the mother, who intentionally destroys the life of an unborn child is guilty of a Class H felony.

940.04(2)

(2) (intro.) Any person, other than the mother, who does either of the following is guilty of a Class E felony:

940.04(2)(a)

(a) Intentionally destroys the life of an unborn quick child; or

940.04(2)(b)

(b) Causes the death of the mother by an act done with intent to destroy the life of an unborn child. It is unnecessary to prove that the fetus was alive when the act so causing the mother's death was committed.

940.04(3)

(3) Any pregnant woman who intentionally destroys the life of her unborn child or who consents to such destruction by another may be fined not more than $200 or imprisoned not more than 6 months or both.

940.04(4)

(4) Any pregnant woman who intentionally destroys the life of her unborn quick child or who consents to such destruction by another is guilty of a Class I felony.

3½ yrs, 10K ea both.

940.04(5)

(5) (intro.) This section does not apply to a therapeutic abortion which:

940.04(5)(a)

(a) Is performed by a physician; and

940.04(5)(b)

(b) Is necessary, or is advised by 2 ~~other physicians~~ as necessary, to save the life of the mother; and

940.04(5)(c)

(c) Unless an emergency prevents, is performed in a licensed maternity hospital.

940.04(6)

(6) In this section "unborn child" means a human being from the time of conception until it is born alive.

940.04 - ANNOT.

History: *2001 a. 109.*

940.04 - ANNOT.

Aborting a child against a father's wishes does not constitute intentional infliction of emotional distress. Przybyla v. Przybyla, 87 Wis. 2d 441, 275 N.W.2d 112 (Ct. App. 1978).

940.04 - ANNOT.

Sub. (2) (a) proscribes feticide. It does not apply to consensual abortions. It was not impliedly

repealed by the adoption of s. 940.15 in response to Roe v. Wade. State v. Black, 188 Wis. 2d 639, 526 N.W.2d 132 (1994).

940.04 - ANNOT.

The common law "year-and-a-day rule" that no homicide is committed unless the victim dies within a year and a day after the injury is inflicted is abrogated, with prospective application only. State v. Picotte, 2003 WI 42, 261 Wis. 2d 249, 661 N.W.2d 381, 01-3063.

940.04 - ANNOT.

This section is cited as similar to a Texas statute that was held to violate the due process clause of the 14th amendment, which protects against state action the right to privacy, including a woman's qualified right to terminate her pregnancy. Roe v. Wade, 410 U.S. 113 (1973).

940.04 - ANNOT.

The state may prohibit first trimester abortions by nonphysicians. Connecticut v. Menillo, 423 U.S. 9 (1975).

940.04 - ANNOT.

The viability of an unborn child is discussed. Colautti v. Franklin, 439 U.S. 379 (1979).

940.04 - ANNOT.

Any law requiring parental consent for a minor to obtain an abortion must ensure that the parent does not have absolute, and possibly arbitrary, veto power. Bellotti v. Baird, 443 U.S. 622 (1979).

940.04 - ANNOT.

Poverty is not a constitutionally suspect classification. Encouraging childbirth except in the most urgent circumstances is rationally related to the legitimate governmental objective of protecting potential life. Harris v. McRae, 448 U.S. 297 (1980).

940.04 - ANNOT.

Abortion issues are discussed. Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983); Planned Parenthood Assn. v. Ashcraft, 462 U.S. 476 (1983); Simopoulas v. Virginia, 462 U.S. 506 (1983).

940.04 - ANNOT.

The essential holding of Roe v. Wade allowing abortion is upheld, but various state restrictions on abortion are permissible. Planned Parenthood v. Casey, 505 U.S. 833, 120 L. Ed. 2d 674 (1992).

940.04 - ANNOT.

Wisconsin's abortion statute, 940.04, Stats. 1969, is unconstitutional as applied to the abortion of an embryo that has not quickened. Babbitz v. McCann, 310 F. Supp. 293 (1970).

940.04 - ANNOT.

When U.S. supreme court decisions clearly made Wisconsin's antiabortion statute unenforceable, the issue in a physician's action for injunctive relief against enforcement became mooted, and it no longer presented a case or controversy over which the court could have jurisdiction. Larkin v. McCann, 368 F. Supp. 1352 (1974).

940.04 - ANNOT.

State regulation of abortion. 1970 WLR 933.